Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES

- 300	Sec.
1	- 7

PRINTED: 01/27/200
FORM APPROVE

(X3) DATE SURVEY

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Υ		
				A. BUILDIN B. WING					
	20,4252,02,045	NVS2725AGC	CTDEET AD	10/21/200					
NAME OF P	ROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE IRTH H STREET					
AGAPE I	OVE FACILITY			AS, NV 8910			. <u>-</u>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE CO	(X5) DMPLETE DATE		
Y 000	Initial Comments			Y 000					
	This Statement of Deficiencies was generated as a result of the annual state licensure survey conducted at your facility on 10/21/08.				RECEI	VED			
					FEB 2 3	2009			
					BUREAU OF LICENSURE AND	CERTIFICATION			
	Administrative Code Facility Groups Reg	nducted using Nevade e (NAC) 449, Reside gulations, adopted by d of Health on July 1	ntial the		LAS VEGAS, NEV				
	The facility was licensed for 4 total beds. The facility had the following category of classified beds: Category 1- 4 beds The facility had the following endorsements: Residential facility which provides care to elderly and/or disabled persons, and /or persons with mental illness.				1 table Po	1/2/09			
					Geregality &	4///			
					Acceptable Po Attachment & Seegele		:		
		ime of the survey wa reviewed and 1 empl							
	There were no com the survey.	plaint(s) investigated	d during						
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:				,				
						7-C-1			
Y 051 SS=D	449.194(2) Adminis Responsibilities-De			Y 051					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

(X6) DATE

		ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER NVS2725AGC		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
						10/2	1/2008
AGAPE LOVE FACILITY 1211 NOF LAS VEGA			1211 NOR	TH H STREI AS, NV 8910			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETE DATE	
Y 000, In	nitial Comments			Y 000			
Ti a	This Statement of Deficiencies was generated as a result of the annual state licensure survey				RECEIVE	D	
co	onducted at your fa	acility on 10/21/08.			FEB 2 3 201	19	
Ad	The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006.				BUREAU OF LICENSURE AND CERT LAS YEGAS, NEYADA	IFICATION	
ТІ	The facility was licensed for 4 total beds.						
	The facility had the following category of classified beds: Category 1- 4 beds						
∣ R∈ ∣ ar	The facility had the following endorsements: Residential facility which provides care to elderly and/or disabled persons, and /or persons with mental illness.						
re		ime of the survey wa eviewed and 1 empl					
1	here were no com ne survey.	plaint(s) investigated	d during				
by pr ac av	y the Health Division rohibiting any crimu ctions or other clai	onclusions of any invon shall not be cons inal or civil investigatims for relief that maty under applicable to	trued as itions, ay be				
	he following regulation	atory deficiencies we	ere				
	49.194(2) Adminis Responsibilities-De			Y 051			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Licensure and Certification

STATE FORM

H10811

(X6) DATE

		NV\$^~?5AGC		B. WING		10/21/2008
	ROVIDER OR SUPPLIER	0	1211 NOR	TH H STREE		10/21/2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRICE OF THE A	JLD BE COMPLETE
Y 051	charge of the facility administrator is abs provided in this sub designated to be in administrator is abs areas of and record Confidential informathe files to which the facility have access is maintained by the administrator or an to be in charge of the subsection shall be times. The name of the facility pursuant posted in a public pall times that the error This Regulation is Based on observat administrator failed employees to be in those times when the Findings include: On arrival to the facto provide the employees.	f a residential ne or more employees y during those times of tent. Except as others section, employees charge of the facility tent must have access ls kept at the facility. ation may be remove e employees in charge if the confidential information administrator. The employee who is des ne facility pursuant to present at the facility f the employee in char at to this subsection may lace within the facility inployee is in charge. not met as evidence ion and interview, the to designate one or charge of the facility he administrator was cility, Employee #2 w loyee files for 3 of the	when the wise when the se to all differentiation signated this yat all arge of each of the wish be y during differentiation signated this arge of each of the wish be yellowed as unable as unable each of the wish be yellowed as unable as unable each of the wish be yellowed as unable as	Y 051	PECEIVE FEB 2 3 200 BUREAU OF LICENSURE AND CERTIFICAS VEGAS, NEVADA Y051 Corrected 10/22/08 Files were presented the following day. In the absent of the Administrator the staff member on duty will be designated as in charge of facility and have access to file cabinets according to 449.194 Monitoring will be conduted on a weekly basis (randously the Administrator. Confidential information be removed and kept by Administrator.	f the o all
	During facility tour, there was no documented evidence seen as to who was in charge of the facility when the administrator was absent. Employee #2 was unable to open the lower locked drawer in the file cabinet.		of the ent.			

NAME OF I	PROVIDER OR SUPPLIER	NVS2725AGC		10/2	10/21/2008		
	STREET ADDRESS, CITY, STATE, ZIP COL. 10/21/20 1211 NORTH H STREET LAS VEGAS, NV 89106						
(X4) ID PREFIX TAG	SUMMARY STATEM (EACH DEFICIENCY MU REGULATORY OR LSC I	MENT OF DEFICIENCE IST BE PRECEDED BE DENTIFYING INFORM	ES	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOLDO	(X5) COMPLETI DATE
	Continued From page On 10/21/08 at 8:30am (Administrator) reveale she was in court and w needed to the Bureau of Certification office the in Employee #1 provided documentation on 10-2 revealed the employee due to a past incident of #1 stated a coordinator Mental Health Services the files locked. Severity: 2 Scope 449.200(1)(f) Personne NAC 449.200 1. Except as otherwise a separate personnel file member of the staff of a (f) Evidence of complian 449.185, inclusive.	an, Employee #1 and per phone corrould bring any ir of Licensure and next day. the requested 24-08. Employee records were no of identity theft. It at Southern Ne at told Employee The state of the state of the state at the state of the st	#1 ot available Employee vada Adult #1 to keep and Check section 2, for each st include: 19.176 to	Y 051	PER 2 BUREAU OF LICENSUR LAS VECA Y105 Corrected 10/22/0 Background Check state have been signed by Employees #1, #2, #3 ar placed in prospective file	SPROPRIATE EIVED 3 2009 HE AND CERTIFICATION S, NEVADA D8 HE ment ad es.	
	Based on record review ensure that 3 of 4 emple background check required history. Findings include:	oyees had met t	he		Monthly monitoring of a will be conducted by the Administrator.		
	Employee #1 was hired personnel file did not co indicating the employee of any crimes listed in N	ontain a signed s had not been c	tatement				

	ATEMENT OF DEFICIENCIES O PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2725AGC ME OF PROVIDER OR SUPPLIER STREET ALL STREET ALL STREET ALL STREET ALL STREET ALL NOTE: The street all ST		CTION IDENTIFICATION NUMBER: A BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/21/2008	
AGAPE I	LOVE FACILITY		1211 NOI LAS VEG	DRESS, CITY, S RTH H STREI AS, NV 8910			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
Y 105	Continued From page 3			Y 105	F	RECEIVED	
	Employee #2 was hired on 7-27-07. The personnel file did not contain a signed statement indicating the employee had not been convicted of any crimes listed in NRS 449.188. Employee #3 was hired on 10-01-02. The personnel file did not contain a signed statement indicating the employee had not been convicted of any crimes listed in NRS 449.188. There was no evidence in the employee file regarding an updated background check report. Severity: 2 Scope: 3 This is a repeat deficiency from survey of 8-01-07.					FEB 2 3 2009 OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	
Y 108	NAC 449. 200 3. The administrator may keep the personnel files for the facility in a locked cabinet and may, except as otherwise provided in this subsection, restrict access to this cabinet by other employees of the facility. Copies of the documents which are evidence that an employee has been certified to perform first aid and cardiopulmonary resuscitation and that the employee has been tested for tuberculosis must be available for review at all times. The administrator shall make the personnel files available for inspection by the bureau within 72 hours after the bureau			Y 108	Y108 Corrected 19 Administrator "on access to employe files and will be a review within 72 h bureau request of Upon absent of Accemployee #4 will authority to present	ly" will have e personnel vailable for nours after inspection. dministrator, have nt files.	
f deficiencie				thin 10 days aft	contain proof of a training and testin Monthly monitor will be conducted Administrator.	Il necessary g required. ing of files by the	

PRINTED: 12/26/2008 FORM APPROVED

Bureau	of Licensure and Ce	rtification				FORM	APPROVED	
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA MBER:	(X2) MULTI A. BUILDIN B. WING _	PLE CONSTRUCTION	(X3) DATE S COMPLE		
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY	STATE, ZIP CODE	10/2	1/2008	
	LOVE FACILITY		1211 NOF LAS VEG	RTH H STRE	ET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FIRE	ID PREFIX TAG	LEACH CORRECTIVE ACTION OF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
Y 108	Continued From pa requests to review	-		Y 108	FE.	CEIVEL B 2 3 2009 ENSURE AND CERTIFIC EVEGAS, NEYADA		
3 T T T T T T T T T T T T T T T T T T T	Based on record re- administrator failed	not met as evidenced view and staff intervi- to ensure employee for immediate review	ew, the files					
The state of the s	to provide the employees (Employees (Employees #4). Employee #4).	cility, Employee #2 wa oyee files for 3 of the ree #1, Employee #3 ployee #2 was unable awer in the file cabine	and e to open	:				
	she was in court an	ealed per phone conv d would have to bring to the Bureau of Lice	g anv i					
e e representamente esta como esta de esta del debesidades est	from the survey. Er employee records we past incident of ider a coordinator at Sou	led the requested inf mployee #1 revealed vere not available du- ntity theft. Employee uthern Nevada Adult I Employee #1 to kee	the e to a #1 stated Mental					
, ne	Employee #3 and E available for immed during the survey. employee files were	Employee #1 (Adminition in the modern that is a market with the modern that is a market when the modern that is a modern that	t uest ated the ottom					

Bureau o	of Licensure and Ce	rtification				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE NVS2725AGC	JMBER: A. BUILDING B. WING		·	(X3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUPPLIER	s	TREET ADD	RESS, CITY, S	TATE, ZIP CODE	10/2	72000
ACABE I OVE EACH ITY				TH H STREI NS, NV 8910			:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPLICATION OF THE APPLICATIO	VULD BE	(X5) COMPLETE DATE
Y 108	Continued From pa	ige 5		Y 108	REC	EIVED	
	cardiopulmonary re				BUREAU OF LICENSUI	3 2009 RE AND CERTIFICATION S., NEVADA	
Y 175	449.209(4)(b) Heal	th and Sanitation-Haza	rds	Y 175			
85	facility must be kep (b) Hazards, includ	acticable, the premises of free from: ing obstacles that impe residents within and out	de the		Y175 Corrected 11/16/0 Bedroom #1 and #2 clo doors have been repaired Hallway closet door have replaced.	sset edd. vve been	
	Based on observat	not met as evidenced to ion and interview, the fa he facility free from haz	acility	1	Laundry Room door, w have been repaired and filled.		
	8:15AM, 2 floor tile (approximately 1 s room floor. One til entrance to the din	dining room of the facilities were noticed to be miquare foot each) on the e was missing as at the ing room and the other ide door of the dining rofloor were rough in	issing dining tile was		Upon each shift, staff versponsible for facility inspection and report a infractions to Administ Administrator will more facility bi-weekly for a treath and Senitation I	illi i rator ilitor ilil	

inch hole in the laundry room floor to the right of the doorway. If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

appearance.

The uncovered wooden walkway located outside the house leading to the laundry room was not properly supported and sagged when walking on

it. The door to the laundry room was off the hinges and had to be moved to gain access to the laundry room. There was approximately a 6 Health and Sanitation H lazards

N\ 125AGC				B' MING T	G		-
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, 8	STATE, ZIP CODE	10/2	/2008
AGAPE I	OVE FACILITY		1211 NOR	TH H STRE AS, NV 8910	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL 1	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD RE	(X5) COMPLETE DATE
Y 175	Continued From page	ge 6		Y 175	DE	CEIVED	
	The Residents have free access to this wooden walkway.		wooden			CEIVED 8 2 3 2009	
	During initial facility tour, it was observed the closet doors in bedroom #1 and bedroom #2 were off the track. One of the doors on the hall closet had been removed. Employee #2 stated the administrator was to have someone come to the facility today to give an estimate for repair to dining room, walkway and laundry room door. Employee #2 indicated residents do not walk on the walkway at this time.				BUREAU OF LIC	ENSURE AND CERTIFICATION VEGAS, NEVADA	
				100			61
	Employee #2 revealed the residents occupying bedroom #1 and bedroom #2 would break the closet doors when they would get upset. This had been a recurrent problem.		ak the			EK.	
	Employee #2 indicatives being repaired, as to when it would	There was no date	nall closet indicated	:		ň	
	The Administrator re an estimate done fo walkway, the laundr the dining room floo she would have the 10 days.	r cost of repairs to t y room door and the r. The administrato	he tiles on r revealed			ž	
	Severity: 2 Scope:	3	:				
Y 453	449.231(2)(c) First /	Aid Kit		Y 453			
	NAC 449.231 2. A first-aid kit mus	it be available at the	e facility.				

B. man e	f Licensure and Ce	differtion (*\				FUKM A	トトドハヘトド
STATEMENT	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA WBER:	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/21/2008	
		NVS2725AGC	CONTROL ADD	DESC CITY ST	ATE, ZIP CODE	1 1021	2000
NAME OF PR	NOVIDER OR SUPPLIER						
AGAPE L	OVE FACILITY			TH H STREE S, NV 89100	5		
(X4) ID PREFIX TAG	CACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	'FULL	PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETE DATE
Y 453	Continued From pa	age 7		Y 453	Y453 Corrected 10/22/0	8	
The first-aid kit must include, without limitation: (c) Adhesive bandages, rolls of gauze and					First Aid Kit have been replaced and included th		
	adhesive tape.				required materials.	-	
					Staff will inspect the be- of each shift and monito weekly by the Administra	ored.	
	Based on observa	s not met as evidence ition, the facility failed	ed by: I to provide			2 3 2009	
	a complete first ai	d kit.				SURE AND CERTIFICATH EGAS, NEVADA	N:
	Findings include:						
	There were no rol	lls of gauze within the	first aid				
	Severity: 1 So	ope: 3	Or.				
Y 455	449.231(2)(e) Fin	st Aid Kit - CPR Masi	k	Y 455			
	The first-aid kit m	nust be available at th nust include, without l nask to be used by a	person who		ti		
	is administering (cardiopulmonary resu	iscitation.		i de		
	This Regulation Based on observ	is not met as eviden	ced by: ed to provide		Y455 Corrected 10/22	/0.08	

Y455 Corrected 10/22/008 First Aid Kit includes CHPR face masks and shields.

Staff will inspect the begginning of each shift and monitopred weekly by the Administ trator.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

a complete first aid kit.

CPR in the first aid kit.

There was no evidence of a shield or mask for

Scope: 3

Findings include:

Severity: 1

If continuation sheet 8 of 1-

STATEMENT OF DEFICIENCIES	
AND PLAN OF CORRECTION	

AGAPE LOVE FACILITY

αn	PROVIDE"	UPPLIER/CLIA
*'''	DENTIF	UPPLIER/CLIA ON NUMBER:

(X2) MULTIPLE	CONSTRUCTION
A. BUILDING	
D MANG	

(X3) DATE SURVEY COMPLETED

10/21/2008

NVS2725AGC

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1211 NORTH H STREET LAS VEGAS, NV 89106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 456	Continued From page 8 449.231(2)(f) First Aid Kit NAC 449.231 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (f) A thermometer or other device that may be used to determine the bodily temperature of a person.	Y 456 Y 456	V456 Corrected 10/22/038	
V 97	This Regulation is not met as evidenced by: Based on observation, the facility failed to provide a complete first aid kit. Findings include: There was no evidence of a thermometer found in the first aid kit. Employee #2 was unable to produce a thermometer. Severity: 1 Scope: 3 449.2742(1)(a)(1) 449.2742(1)(a)(1) Medication	Y 870	First Aid Kit includes a thermometer. Staff will inspect the begginning of each shift and monitoored weekly by the Administ trator. RECEIVED BUREAU OF UCENSURE AND SEATONC LAS YEGAS, NEVADA	
Y 8/	NAC 449.2742 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary			

YU PUAN U	F CORRECTION	NVS: AGC	MOEN.	A. BUILDING B. WING		10/21	/2008
	COVIDER OR SUPPLIER OVE FACILITY	8	STREET ADDR 1211 NORT LAS VEGA	'H H STREE			
(X4) ID PREFIX TAG	EACH DEECENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
Y 870	Based on record review, the facility falled ensure a medication profile review was performed by a physician, pharmacist or registered nurse at least once every six not 2 of 2 residents residing in the facility		Y 870	R	ECFINE	86	
ļ	supplements taken	by a resident.			F	EB 2 3 2009	
						LICENSURE AND CERTIFICA LAS VEGAS NEVADA	ion-
	This Regulation is	not met as evidence	ed by:		is.		
	Based on record re ensure a medication performed by a phy registered nurse at for 2 of 2 residents	erformed by a physician, pharmacist or gistered nurse at least once every six months or 2 of 2 residents residing in the facility for nger than six months (Resident #1 and #2).			Y870 Corrected 10/2 Medication profile was reviewed every 6 months physician, pharmacing registered nurse of nu	onths by a store	
	Findings include:				in the facility.		
	enend The last	dmitted to the facilit medication profile re cord was dated 12-6	EAISM		The Administrator versponsible party to review.	will be the insure	
	40 42 06 The las	idmitted to the facili it medication profile cord was dated 12-4	16AICM		-		:
	Severity: 2 Scope	e: 3	1.7				
Y 88	3 449.2742(7) Medi	cation / Resident Re	efusai	Y 883			
		fuses, or otherwise medication, a physi hours after the dos	Pierri Hillians and				
W deficier	This Regulation	is not met as evide	enced by:	within 10 days	s after receipt of this statement of de H10811	ficiencies. (f contin	wation sheet

AND PLAN OF CORRECTION

ILENTIFICATION NUMBER.

PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM NVS2725AGC	WBERC	A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SU COMPLE 10/21	/2008
	OF PROVIDER OR SUPPLIER		1211 NOR	RESS, CITY, STA TH H STREET AS, NV 89106			#!"
) ID EFTX AG	SUMMARY S	TATEMENT OF DEFICIENCI CY MUST BE PRECEDED BY R LSC IDENTIFYING INFORM	ES (FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CI (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE IE APPROPRIATE	(XS) COMPLETE DATE
7 883 Y	failed to ensure to 2 residents remedication (Resident #2 was 90 micrograms times daily. The placed on the 10 (MAR) by Albut 2008 through of a prescripti was no notation medication. Employee #2 use the Albutt she did not knot filed and to on the MAR. Severity: 2	ew and record review, he physician was noti fused to take the orde ident #2).	ned O6. Albutero be given 4 r initials tion record onths (June was no cop ord. There i to take the refused to e #2 reveals ded to be be document	ay .	Y883 Corrected 16 Staff has reviewed and shall notify A immediately upon refusal or missed that a physician is within 12 hours of the staff and Adminiverify prescription and document all medication(s), remissed doses. Staff will be mon by Administrator	d procedure dministrator resident medication s notified of occurrence. distrator will ons are on file administered efusal of, or	09
	provides ass administration (b) A record each reside	nistrator of a resident sistance to residents in on of medication shall of the medication add int. The record must indicate and time that a re e misses, an administ	maintain: ministered to nclude: esident refu				

TATEMENT ND PLAN OF	OF DEPICIENCIES CORRECTION	(X1) PROVIDE SUPPLIE (DENTIFI ON NUR	MBER:	A. BUILDING B. WING		(X3) DATE SUI COMPLET	RVEY ED /2008
- 12	OVIDER OR SUPPLIER		1211 NORT	RESS, CITY, ST TH H STREE S, NV 89106	ATE, ZIP CODE T		
(X4) ID PREFIX TAG	YEARLI DEEKTEN	TATEMENT OF DEFICIENCE CY MUST BE PRECEDED BY LISC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TOJTHE, DEFICIENCY)	SHOULD BE.	(X5) COMPLETE DATE
Y 897	Based on intervier failed to document medication for 1 in Findings include: Resident #2 was 90 micrograms (in times daily). The placed on the medication for 1 in Findings include: 1. **Comparison** 1.	is not met as evidence w and record review, nt resident refusal of a of 2 residents (Reside admitted on 10-13-06 mcg), 2 puffs was to bare are no caregiver in edication administration of for the past 5 months.	int #2). 3. Albuterol le given 4 litials on record lits (June led she did notified and	Y 897	BUREAU OF LIC	esher gement ave been n another nt cument	
Y 898	NAC 449.2744 1. The administ provides assist administration (b) A record of each resident.	rator of a residential fance to residents in the medication shall mathe medication adminitures for administering the record must include the t	ie sintain: istered to ude: the	Y 898	·		
	The administration of the control of the contr	ance to residents in the medication shall matthe medication adminition administration adminition adminition adminition adminition adminition adminition administration ad	ie aintain: istered to ude: the t the current	3 4		E ₂	

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Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROV IDENT		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SU COMPLE			
		NVS2725AGC		B. WING		10/21	21/2008	
NAME OF D	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, ST	ATE, ZIP CODE			
	OVE FACILITY			TH H STREE AS, NV 8910				
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE	
V 898	Continued From page	age 12		Y 898		RECEIVE	3	
1 030	Contanace					FEB 2 3 200		
5	Based on interview	s not met as evidence w and record review,	the facility		BURE	AU OF LICENSURE AND CERTIF LAS YEGAS, NEVADA	,4T-05-	
	failed to ensure m	edication administere	ed renects	1	Y898 Corrected 2/12	2/09		
	the current order of	of the residents physi	cian in 2 of		Staff #2, #3 and #4 h		1	
	2 residents (Resid	ICH # I GHU #2J.			retaken Medical Ma	nagement		
	Findings include:				Class on 2/12/09.			
	1 Decident #1 Wa	as admitted to the fac	ility on			iourad		
	6-26-01 The pha	armacy label on the F	iber-Lax		Administrator have	revieweu de of the	1	
	bottle indicated 2	tablets were to be gr	ven at	1	and corrected record medication administ	is of the		
	breakfast and din	ner.			each resident.	tered to		
	The Medication A	dministration Record	(MAR)	1	each resident.			
	ia unillan ta aiv	ia Fihariax 1 tablel a			Staff have been rep	rimanded		
	The MARC	reviewed (June 2006) I were written to prov	o u ji Quyiri	1	and advised on nex	t	-	
	at Sam and Som.	There was no docu	Mentea	1	occurrence will was			
	evidence of the o	original physician orde	er.		dismissal.		1	
	Employee #2 wa not being given a	s not aware the Fiber as ordered by the phy	r Lax was vsician.		- 122 pa			
	milligrams (mg), not indicated on	ordered Seroquel 30 take 2 at bedtime. So the October MAR. The on 9/23/08. Emplaining pills. There we	he bottle of lovee #2		=			
		vealed Resident #1 beroquel and was not so ot written on the MAI	and and an	e				
	10-13-06. The	was admitted to the f pharmacy label on th g tablets, take 2 table MAR for June 2008,	ets at luk 2008.		after receipt of this statement of	neficiencies.		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

H10811

STATE FORM

Bureau of Licensure and Certification (X3) DATE SURVEY (XZ) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING B. WING 10/21/2008 NVS2725AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1211 NORTH H STREET** LAS VEGAS, NV 89106 AGAPE LOVE FACILITY PROVIDER'S PLAN OF CORRECTION (73) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) RECEIVE Y 898 Continued From page 13 Y 898 August 2008, September 2008 and October 2008 FEB 2 3 2001 indicated the dosage was 2mg. BUREAU OF LICENSURE AND CERTIF CATION-LAS YEGAS, NEVADA Employee #2 was shown the medication bottle and the MAR. Employee #2 was not aware there was a discrepancy between the written dose and ordered dose of the DDAVP. This was a transcription error. Scope: 3 Severity: 2 Y 899 Y 899 449.2744(2) Medication Administration NAC 449.2744 2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the Y899 Corrected 1/09/09 administration of medication to a resident. This requirement may be met by including on a Staff has retaken Medical resident's medication sheet an indication of who Management Class on 2/12/09. assisted the resident in the administration of the medication, if the caregiver can be identified from Staff have been advised and this indication. reprimanded on medication log and signature. Next occurrence will warrant dismissal. Administrator will monitor log This Regulation is not met as evidenced by: daily. Based on record review, the facility failed to ensure evidence of caregiver signatures on the Medication Administration Record (MAR) to document resident medication assistance for 2 of 2 residents (Resident #1 and #2). Findings include:

Bureau d	of Licensure and Ce	rtification				FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2725AGC			(X2) MULTIPI A. BUILDING B. WING		(X3) DATE SI COMPLE		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	TATE, ZIP CODE	10.12	172000
AGAPE I	OVE FACILITY			TH H STREE S, NV 89100			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
Y 899	6-26-01. There was a signature of the enter the medication on the signature of the enter the enter the signature of the enter the e	dmitted to the facility is no documented evernployee who adminithe MAR for the monion, August 2008, Separated to the facility as no documented evernployee who adminithe MAR for the monion, August 2008, Separated evernployee.	idence of istered this of otember on vidence of istered this of	Y 899		ECEIVED EB 2 3 2009 LICENSURE AND CERTIFICAT LAS VEGAS, NEVACA	
Y 938	resident of a reside least 5 years after facility. The file methat is resistant to unauthorized use. records, letters, as information and arthe resident, including An evaluation of perform the activit description of any perform those activity an evaluation of any perform those activity and activity activity.	nust be maintained for the permanently leave ust be kept locked in fire and is protected. The file must contains essments, medically other information of the resident's abilities of daily living and assistance he needsivities. The facility should receive the resident's abilities.	ined for at les the a place against on all related to a brief a to hall prepare	Y 938	Y938 Corrected 10/2: ADL assessment have performed on all residual placed in their files. The Administrator is responsible for maintain and monitoring of files.	e been lents and aining	

Bureau o	of Licensure and Ce	rtification				FORM	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIP A. BUILDING B. WING		(X3) DATE SI COMPLE	
NAME OF P				RESS, CITY, S	TATE, ZIP CODE	1.02	.,2000
AGAPE L	OVE FACILITY	•		TH H STREE S, NV 8910			
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Y 938	Continued From pa	age 15		Y 938		RECEIVE	D
			Ì			FEB 2 3 200	9
	Based on record re perform an evaluar abilities to perform	not met as evidence eview, the facility faile tion on 1 of 2 residen the activities of daily sion to the facility (Re	ed to its for their living		BA	UREAU OF LICENSURE AND CERTI LAS YEGAS, NEVADA	CATION THE
	Findings include: Resident #2 was a 10-13-06. The res	admitted to the facility sident's file did not co upon admission to th	ntain an		-		
	Severity: 2 Scor	•	e lacinty.				
Y 940	449.2749(1)(g)(3)	Resident file		Y 940			
	resident of a resident of a resident of a resident facility. The file methat is resistant to unauthorized use records, letters, a information and a the resident, includes of an exclusion of any description of any	must be maintained in lential facility and retain the permanently leave to fire and is protected. The file must contains essessments, medicain of the resident's abilities of daily living and assistance he need to the resident's abilities. The facility stations are security as a security and the resident's abilities of daily living and the resident's abilities. The facility stations are security as a security as a security and the resident's abilities.	ained for at ves the n a place lagainst all li related to on: ity to d a brief lis to		Y940 Corrected 10 Annual evaluations ADL have been pla residents file. The Administrator are responsible par maintaining and re files for at least 5	s of the aced in aced in and Staff #4 rties for etention of	

(3) In any event, not less than once each

уеаг.

		OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING			(23) DATE 8		
	NVS2725AGC			B. WING		10/2	1/2008
1211 NOS		1211 NORT	RESS, CITY, ST TH H STREE S, NV 89101				
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Y 940	Continued From p	page 16		Y 940		RECEIV	cn.
			- 1				Access.
		s not met as evidence review, the facility faile		Š		FEB 2 3 2	
-	perform an annual ability to perform	every, the facility take all evaluation of a reside the activities of daily in iding in the facility long	ent's ving on 2			BUREAU OF LICENSURE AND O LAS YEGAS, NEVA	SHIFICATION
	Findings include:				(*)		
	6-26-01. The res	admitted to the facility ident's file did not cont of the resident's abilities of daily living for 2	tain an ly to				
:	10-13-06. The re	admitted to the facility esident's file did not con of the resident's abilities of daily living for 2	ntain an ly to		Ke T		
	Severity: 2 Sco	оре: 3					
Y 941	449.2749(1)(h) F	Resident file		Y 941	20		
	resident of a resident of a resident of a resident state is resistant unauthorized us records, letters, information and the resident, inc	e must be maintained in idential facility and retained facility and retained in the permanently lead must be kept locked in the fire and is protected assessments, medical any other information studing without limitation thes for the facility that	ained for at ves the n a place I against ail all related to on:		fier receipt of this statement of		

Bureau o	of Licensure and Cer	rtification					APPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SI COMPLE	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	TATE, ZIP CODE	1002	
AGAPE I	OVE FACILITY			TH H STREE S, NV 89106			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
Y 941	y 941 Continued From page 17 by the administrator of the facility and the or a representative of the resident.		ne resident	Y 941		FEB 2 3 2009 of Licensure and Certificate Vegas, Nevada	
	Based on record rethe rules of the facility and/oreviewed (Resident Record Review Resident #2 was a 10-13-06. Review Resident #2 failed of the facility and the	dmitted to the facility of the medical recor to provide evidence signed by the admin	ed to have ministrator f 2 records on ds on the rules		Y941 Corrected 1/09/Separate files are to be residents for at least 5 a locked place and ag destruction Administrator and resigned the rules of the and in files. The Administrator are responsible particular and rete files for at least 5 years.	e keept on yeears in ain 1st any sideent has a faacility and Staff #4 es for ntioon of	